Leave Recipient Application
Under The Voluntary Leave Transfer Program

1. Applicant's Name *(Last, First, Middle)*	2. Social Security Number	3. Employee Number

4. Position Title, Pay Plan, and Grade/Pay Level

5. Name of Organization *(Agency, Department, Office, Division, Branch, etc.)*	6. Payroll Office Number

7. Nature and Severity of the Medical Emergency

8. Individual Affected by Medical Emergency *(Check one)*	9. Date Medical Emergency Began	10. Date Medical Emergency Ended *(Or is Expected to End)*
[ ] Employee [ ] Employee's Family Member		

11. Name of Physician Who Will Verify the Medical Emergency *(Attach documentation from the physician (or other appropriate expert) showing the diagnosis, prognosis and duration of the illness.)*

12. What is the Applicant's Leave Balance as of End of Last Pay Period?	13. How Many Hours of Leave Without Pay Have Been Used for This Medical Emergency?

14. Does the Applicant Want a Description of the Medical Emergency Distributed to Servicing Personnel Offices so that Other Employees May donate Leave to the Account?   [ ] No   [ ] Yes   If "Yes," Provide the Description Below.

[ ] Check. If the Applicant Does Not Wish to Have Name Used With the Description or Disclosed to Anyone Except Supervisor, the Supervisory Channel and the Deciding Official, and Individuals Who Maintain the Program.

15. Name of Individual Completing the Application *(If Applying on Behalf of the Applicant)*	Relationship to Applicant	Telephone Number

16. I Certify that the Above Statements are True. Signature of Applicant or Individual Applying on Behalf of the Applicant	Date Signed

Privacy Act Statement

17. First Level Supervisor's Recommendation, Signature, and Date Signed	18. Deciding Official's Decision, Signature and Date Signed
[ ] Approve [ ] Disapprove	[ ] Approve [ ] Disapprove

REPRODUCE LOCALLY   PerFORM (DLA)